the breast center at Hope

An affiliate of Hope–A Women's Cancer Center

BONE DENSITY MEDICAL HISTORY

Patient Name: ____ **Date:** ____________________

Date of Birth: ____________________**Age:**______ **Weight:** ____________ **Height:** _____________

❑Yes ❑No Have you had any test in the past week that required contrast (oral or Injection)?
❑Yes ❑No Have you had any loss in height? If yes, how much? _____________________
❑Yes ❑No Have you had any recent (within 5 years) fractures of the spine, hip, pelvis or long bone?
❑Yes ❑No Have you ever had hip or spine surgery?
❑Yes ❑No Do you have a family history of Osteoporosis?
❑Yes ❑No Do you have hyperparathyroidism or a high calcium level in your blood?
❑Yes ❑No Are you on thyroid medications? (Synthroid, Thyroxin, etc)
❑Yes ❑No Are you on a Corticosteroid therapy? (Prednisone, Cortisone, etc)
❑Yes ❑No Do you have a personal history of cancer? If yes, type:_____________________
❑Yes ❑No Did you have chemotherapy treatment?
❑Yes ❑No Do you take calcium supplements? Have you taken any in the last 24 hours? ❑Yes ❑No
❑Yes ❑No Have you ever smoked cigarettes? If yes, how long? _________________________

Have you been or currently being treated with the following medications?

MEDICATION	EVER	CURRENTLY	HOW LONG
Hormone replacement therapy			
Tamoxifen			
Evista			
Fosamax			
Actonel			
Boniva			
Aromasin			
Arimidex			
Aredia			
Maicalcin nasal spray			
Forteo			
Zometa			
Femara			

For women only…

❑Yes ❑No Have you gone through menopause? If yes, at what age? ________________________
❑Yes ❑No Did you have premature menopause due to ovarian removal or ovarian failure? If yes, at what age? ______________________